Canadian Medical Education Journal

Commentary and Opinions

Lost in translation: the case for embedding newcomer care in medical education

Perdu dans la traduction : l'intégration de la prise en charge des nouveaux arrivants dans l'éducation médicale

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Edited by: Marcel D'Eon (editor-in-chief)

Published ahead of issue: Oct 16, 2023; published: Dec 30, 2023. CMEJ 2023, 14(6) Available at https://doi.org/10.36834/cmej.78045

Canada has one of the highest rates of immigration in the world, with migrants making up 23% of the population, and the country resettling almost half a million newcomers annually.[1] Thus, the medical community should not view migrants as a special interest group, but an integral part of Canadian life and landscape. It is time we recognized the importance of providing culturally safe, evidence-based healthcare and re-settlement services for immigrants and refugees as an issue that affects all of Canada. The COVID-19 pandemic magnified many health inequities that newcomers face, such as front-line exposure risks, difficulty accessing COVID-19 testing, mental health concerns and barriers to accessing health services and settlement supports. Medical education plays an essential role in educating future physicians about these topics and reducing barriers to care.

Migration itself can and maybe should be thought of as a determinant of health, with biological, social, economic, and logistical factors at play.[2] Biologically, many newcomers come from countries endemic for certain illnesses that physicians may fail to screen for. Socially, many migrants face racism, discrimination and challenges integrating into Canadian society, a stressful experience which is associated with negative health outcomes.[2] Economically, coverage for health services exists on a spectrum in Canada, with variability in access depending on the newcomer's migration status and differing federal and provincial requirements.[3] Also contributing heavily to health inequities are additional barriers in accessing health services such as the lack of availability of family physicians with language and cultural skills accepting newcomer patients.[3]

One opportunity for improvement in cultural competency is the use of interpretation services. A 2021 study found that 60% of immigrant survey respondents report using friends or family members when interacting with health care providers.[4] This poses an issue, as trained medical interpreters have been shown to better facilitate care, with a reduction in communication, diagnostic, and medical errors. [5] The problem exists both at a systemic level with some areas not having interpretation services, but also at the individual physician level, as some physicians simply opt to not use this service despite it being available. Education about this matter, starting at the medical school level, is one way to increase the normalization of these services, shift healthcare models and ultimately provide better care.

Medical education can help mitigate health disparities and reduce barriers to care for migrants when focused on trauma-informed care, cross-cultural communication, anti-racism and information on refugee health.[6] Cultural safety in a physician-patient relationship allows patients to be more open with and trusting of physicians, to give more complete histories and be more forthcoming and thus more likely to follow medical advice.[4] This results in improved health outcomes, increased patient satisfaction, and reduced healthcare spending on further health complications resulting from a weak therapeutic alliance.[6]

Beyond instilling cultural safety principles in students, education on how to advocate for patients can also help mitigate the inequities that migrants face. If students can be taught how to use their expertise and influence to affect change within their communities, this can improve health outcomes at a systemic level.[7] There is hope in better education, yet the road ahead is not easy as there are many barriers to curriculum change.[8]

Medical education programs across the country have a duty to promote social accountability. For instance, The Royal College of Physicians and Surgeons of Canada includes indigenous knowledge explicitly in their "medical expert" role within the CanMEDS framework, stating that the "culturally competent physician embraces Indigenous knowledge and the significance of forbearance in Indigenous culture; this shows a true understanding of how historical legacies affect Indigenous people."[9] As a result, many medical schools now partake in cultural safety teaching and community engagement initiatives to connect medical students with Indigenous communities. Furthermore, anti-racism and anti-oppression are topics that will be emphasized in the upcoming 2025 updated CanMEDS framework.[10] While these initiatives are long-overdue, and only in their beginning stages, with Indigenous patients in Canada continuing to face barriers and discrimination when accessing healthcare, these early efforts serve as valuable lessons in the importance of honouring lived experience, working with communities, and understanding historical and ongoing inequalities and injustices. Medical schools would benefit from taking similar steps to develop curriculum centered around migrant and refugee health. In 2022, the Canadian Collaboration for Immigrant and Refugee Health Network published an undergraduate medical education framework for refugee health curriculum that can be adopted by medical programs, modeled from other CanMEDS frameworks.[7] Such tools can and should be utilized by medical programs across Canada to develop their curriculum on immigrant and refugee health.

Despite most Canadian medical programs having some level of learning objectives in this area, large gaps still exist, such as specific learning objectives about post-traumatic stress disorder (PTSD) or reproductive health issues in migrants.[11] Migrants bear increased rates of PTSD and depression and major inequalities in reproductive health care access. A lack of formation, education, and training in this area is a disservice to medical students and their future migrant patients. Given the scope and intersectionality of immigrant and refugee health in Canada, more must be done to bridge this gap. Newcomers are not a special interest group, but represent almost a quarter of the Canadian population, and health education on their needs should no longer be an afterthought.

Conflicts of Interest: The author has no competing interests.
Funding: No funding.
Acknowledgements: Thank you to Dr. Jessie Breton and Rhianna Charchuk for their help with this article and for advocating for migrant health as part of the Refugee Health Coalition.

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